PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HU[illegible] J SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 3/26/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story Type V(111), unprotected, combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1990 K7 SURVEY UNDER: 2000 EXISTING K8 SNF	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include:	K 018	**K018 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** All corridor doors identified to include Room numbers 113, 124, 126, 213, and 225 have been repaired as of 2/18/11 so that they now close to a positive latch. **How will the facility identify other residents with the potential to be affected by the deficiency?** All residents have the potential to be affected. Training, systemic changes, audits, and a performance improvement program as described below have been implemented to ensure all corridor doors close to a positive latch so that our residents are well protected in case of a facility fire. **What systemic change will be put into place to ensure the practice will not re-occur?**	3/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jennifer B. Henderson, Executive Director, 2/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Observation and interview with the Maintenance Director during the fire drill on February 7, 2011 at 3:30 p.m. confirmed corridor doors to residents rooms 113, 124, 126, 213, and 225 failed to close to a positive latch.	K 018	Staff Development Coordinator (SDC) inserviced all staff (to include the Maintenance Director) on Fire Procedures on 2/18/11, and that anytime any associate notices that a door is not latching they must fill out a work order immediately and notify maintenance so that it can be repaired immediately. SDC also inserviced all staff on 2/18/11 that along with each monthly fire drill every door in the facility must be checked to ensure they all close to a positive latch. Any doors found out of compliance will be repaired/replaced immediately. **How will the facility monitor and ensure the deficiency is corrected and will not re-occur?** Maintenance Director or designee will check every facility door for latching 2 times per month (one of these checks will be performed as a part of the monthly fire drill). This will be done 2 times per month for 3 months or until 100% compliance is achieved. After 100% compliance is achieved door latch checks will occur 1 time per month during the monthly fire drill. All doors found to be out of compliance (not latching) will be immediately repaired/replaced. Maintenance Director will report findings to the PI committee for 3 months for recommendations and follow up. Performance Improvement committee includes the ED, DON, Medical Director, Consultant Pharmacist, Maintenance Director, and interdisciplinary department heads.	3/26/11

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K 018	Continued From page 1 Observation and interview with the Maintenance Director during the fire drill on February 7, 2011 at 3:30 p.m. confirmed corridor doors to residents rooms 113, 124, 126, 213, and 225 failed to close to a positive latch.	K 018		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:00 p.m. confirmed unsealed penetrations in the following locations: 1) Kitchen ceiling above the hood suppression system cylinder 2) Kitchen ceiling on the side of the hood near the gas line, 3) Kitchen wall above the door from the kitchen to the service hall 4) Electrical room wall adjacent to boiler room	K 029	**K029 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** In order to assure the facility's fire rated construction is maintained in hazardous areas the following corrections have been/will be made: 1) Kitchen ceiling penetration above the hood suppression system cylinder has been sealed with approved/appropriate materials. 2) Kitchen ceiling penetration on the side of the hood near the gas line has been sealed with approved/appropriate materials. 3) Kitchen wall penetration above the door from the kitchen to the service hall has been sealed with approved/appropriate materials. 4) Electrical room wall penetration adjacent to boiler room will be repaired with approved/appropriate materials prior to 3/26/2011.	3/26/11

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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:00 p.m. confirmed unsealed penetrations in the following locations: 1) Kitchen ceiling above the hood suppression system cylinder 2) Kitchen ceiling on the side of the hood near the gas line, 3) Kitchen wall above the door from the kitchen to the service hall 4) Electrical room wall adjacent to boiler room	K029 K 029	5) The 2 hour fire rated wall in the boiler room will be repaired so as to eliminate water damage, penetrations, and restore the integrity of the 2 hour fire rating with approved/appropriate materials by 3/26/2011. 6) Ceiling penetration above the phone lines will be repaired with approved/appropriate materials by 3/26/2011. 7) The ceiling penetration in the laundry in the room behind the dryers will be repaired with approved/appropriate materials by 3/26/2011. **How will you identify other residents having the potential to be affected by the same deficient practice?** Maintenance Department will inspect all facility hazardous areas to assure the fire rated construction is maintained to include no penetration violations. Any violations found will be immediately scheduled for repair in accordance with regulations. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Maintenance Director/Executive Director will ensure that facility hazardous areas are inspected to ensure that they maintain their appropriate fire rating without unsealed	3/26/11

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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:00 p.m. confirmed unsealed penetrations in the following locations: 1) Kitchen ceiling above the hood suppression system cylinder 2) Kitchen ceiling on the side of the hood near the gas line, 3) Kitchen wall above the door from the kitchen to the service hall 4) Electrical room wall adjacent to boiler room	K029 K 029	penetrations after any future facility repair work/installations/construction involving fire rated hazardous areas in the facility. **How will the corrective actions be monitored to ensure the deficient practice will not recur?** Facility hazardous areas will be placed on a preventative maintenance inspection schedule to occur quarterly, and after any facility repair work/installations/construction involving fire rated hazardous areas in the facility. Maintenance director will maintain all records pertaining to ensuring the appropriate fire rating of the facility's hazardous areas.	3/26/11

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K 029	Continued From page 2 5) Boiler room 2-hour wall by gas hot water heaters had numerous openings as well as significant water damage 6) Ceiling above phone lines 7) Laundry in ceiling behind dryers	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure exits failed to discharge to a public way. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:00 p.m. confirmed the exit by room 117 discharged to a sidewalk that ended at an unmarked privacy fence gate. No exit path was visible to a public way.	K 038	**K038 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Latches will be removed and spring loads will be placed on each of two gates which access this exit path to a public way. This will allow the gates to be opened by pulling on one side of the gate and pushing on the other side. Signs will be posted on the gates as to whether one should push or pull. When not in use the spring will help keep the gate closed. Exit signs will also be placed on both gates. Lighting with at least two bulbs that are both run off emergency power will illuminate the sidewalk exit path through the Activities courtyard. This will all be complete by 3/26/2011. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. The changes identified above will prevent future residents from being adversely affected.	3/26/11

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure exits failed to discharge to a public way. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:00 p.m. confirmed the exit by room 117 discharged to a sidewalk that ended at an unmarked privacy fence gate. No exit path was visible to a public way.	K038 K 038	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Maintenance Director or designee will complete preventative maintenance checks on the new spring loaded gate and illumination system for the exit path in this area. Any future violations identified in these checks will be immediately repaired. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Maintenance Director will provide a report of the preventative maintenance findings for the activity courtyard exit area to the Performance Improvement committee for 4 months for recommendations and follow up. Preventative Maintenance checks will continue 1 time per month and any violations found will be immediately repaired. Performance Improvement committee includes the ED, DON, Medical Director, Consultant Pharmacist, Maintenance Director, and interdisciplinary department heads.	3/26/11

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K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 045	K045 NFPA 101 LIFE SAFETY CODE STANDARD **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Appropriate lighting to comply with state and federal regulations has been ordered, received and is in the process of being installed. These are dual light fixtures to which the power will run off our generator when there is a facility power failure, thus never leaving a means of egress in darkness. This installation will be complete prior to 3/26/2011. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. The changes identified above will prevent future residents from being adversely affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director or designee will complete monthly preventative maintenance checks on the illumination system for the facility outdoor means of egress. Any future violations identified in	3/26/11

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K 045	Continued From page 3 failed to assure exits paths were lighted so the area would not be in total darkness. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 9:20 a.m. confirmed the outside lights at the exits by rooms 123, 217, and 227 were not provided with multiple lights.	K 045	these checks will be immediately repaired. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Director will provide a report of the preventative maintenance findings on the illumination system for the facility outdoor means of egress to the Performance Improvement committee for 4 months for recommendations and follow up. Preventative Maintenance checks will continue 1 time per month and any violations found will be immediately repaired. Performance Improvement committee includes the ED, DON, Medical Director, Consultant Pharmacist, Maintenance Director, and interdisciplinary department heads.	3/26/11

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K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure smoke detectors were located at least 3 feet from an air supply (NFPA 72, 2-3.5.1). The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 8:45 a.m. confirmed the smoke detectors by rooms 211, 102, and 125 were located 1-foot from an air supply.	K 052	K052 **K052 NFPA 101 LIFE SAFETY CODE STANDARD** **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Maintenance department will ensure that a two way diffuser is installed in all air supply vents of the building (to include air supply vents located by rooms 211, 102, and 125) in which their location is less than 3 feet from a smoke detector. These two way diffusers will be installed so that air is diffused in a way so that its flow will not interfere with smoke detection. In conversations with Stuart Hurwitz on 2/7/11 and 2/17/11 this means of resolution was verbally approved as one appropriate means of resolution to bring us into compliance with regulations. These diffusers will be installed prior to 3/26/11. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. The changes identified above will prevent future residents from being adversely affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	3/26/11

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K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure smoke detectors were located at least 3 feet from an air supply (NFPA 72, 2-3.5.1). The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 8:45 a.m. confirmed the smoke detectors by rooms 211, 102, and 125 were located 1-foot from an air supply.	K 052	K052 Maintenance department will ensure that if/when any new air supply vents or smoke detectors are added in the future they will be placed at least 3 feet away from each other. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Maintenance director/Executive director will collaborate to ensure that if/when any new air supply vents or smoke detectors are added in the future they will be placed at least 3 feet away from each other. Maintenance director will maintain all records pertaining to installation of any new air supply vents and/or smoke detectors.	3/26/11

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	K062 **K062 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** In order to comply with the standard that states we are to assure that our sprinkler heads are free of corrosion the sprinkler head in the boiler room, which was found to have been corroded, was replaced on 2/11/11 by Simplex Grinnell. Prior to 3/26/11 and quarterly the maintenance department will inspect/ensure inspection of all facility sprinkler heads for corrosion. Any sprinkler heads found to have any corrosion will be immediately scheduled for replacement. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. The procedures identified above will prevent future residents from being adversely affected. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director or designee will complete/ensure completion of quarterly	3|26|11

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	445275	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2011

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K 062	Continued From page 4 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure sprinkler heads were free of corrosion. The findings include: Observation and interview with the maintenance director on February 7, 2011 at 9:50 a.m. confirmed the sprinkler head in the boiler room was corroded.	K 062	sprinkler checks for corrosion on all facility sprinkler heads. Any sprinkler heads found to have any corrosion will be immediately scheduled for replacement. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Maintenance Director/Executive Director will ensure that as soon as any corrosion is identified on any sprinkler head during a quarterly check that the sprinkler head is immediately scheduled for replacement. Maintenance director will maintain all records pertaining to sprinkler head preventative maintenance and replacement.	3/26/11
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure commercial cooking equipment was provided with proper suppression system for the components under the cooking hood and that it complied with NFPA 96. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:45 p.m. confirmed the six burner stove and griddle was located under nozzles where two (2) deep fryers used to be with #230 nozzles.	K 069	**K069 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** In order to assure commercial cooking equipment is provided with the proper suppression system for the components under the cooking hood and to assure compliance with NFPA 96, Life Care Center of Jefferson City Executive Director and Maintenance Director are taking the following actions: 1) Had Simplex Grinnell come to facility on 2/8/11 to ensure our hood system was appropriately set up for the cooking equipment under it. To achieve compliance with regulations, they replaced 2 230 nozzles with 2 260 nozzles,	3/26/11

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K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure commercial cooking equipment was provided with proper suppression system for the components under the cooking hood and that it complied with NFPA 96. The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 2:45 p.m. confirmed the six burner stove and griddle was located under nozzles where two (2) deep fryers used to be with #230 nozzles.	K069	**What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?** Any time any new kitchen equipment is considered for purchase that would require placement under the hood Maintenance Director/Executive Director will contact State Fire Safety Specialist for guidance and will follow all recommended procedures and get all recommended approvals prior to the installation of this equipment. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Any time any new kitchen equipment is considered for purchase that would require placement under the hood Maintenance Director/Executive Director will contact State Fire Safety Specialist for guidance and will follow all recommended procedures and get all recommended approvals prior to the installation of this equipment. Maintenance director will maintain all records pertaining to appropriate hood system setup in consideration of type of equipment under it.	3|26|11

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		K072	**K072 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Service hall corridor was cleared. Meeting led by Executive Director was held with Dietary Manager, Central Supply, Environmental Services Manager, and Maintenance Director on 2/16/11 to establish a plan for keeping the service hall clear. Dietary Manager and Environmental Services Director identified a room across the hall from Central Supply (a room that opens to the service hall) that they no longer needed to use. Central Supply will now be placing any overstock they have into this room until it is needed for use or for stocking on the floors. Dietary Manager, Housekeeping Supervisor, Maintenance Director and Central Supply will place incoming stock into an appropriate storage location as soon as it is received. Any remaining items from any department will be taken to the appropriate storage building immediately.	3/26/11
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072	**How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. The procedures identified herein	

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K 072	Continued From page 5 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the corridors in the means of egress were maintained clear of all obstructions (NFPA 101- 7.1.10.2.1.) The findings include: Observation and interview with the Maintenance Director, on February 7, 2011 at 1:30 through 4:30 p.m. confirmed the service hall corridor had boxes and other combustibles along 30-feet length of the wall.	K 072	will prevent future residents from being adversely affected. **What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?** In order to assure the corridors in the means of egress are maintained clear of all obstructions Maintenance Director/Central Supply Associate/Environmental Services Supervisor or designee will observe the service corridor and all egress corridors each morning. Maintenance Director/Central Supply Associate/Environmental Services Supervisor or designee will resolve any violations/clear any egress obstructions in corridors, and will report findings to ED daily. **How will the corrective action be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?** Maintenance Director/Central Supply Associate/Environmental Services Supervisor or designee will observe service corridor and all egress corridors each morning, will resolve any violations/clear any egress obstructions in corridors, and will report findings to ED daily for three months, or until 100% compliance is achieved. Maintenance	3/26/11

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